Beth Israel Lahey Health
Beth Israel Deaconess Medical Center
330 Brookline Avenue / Medical Records
RA-0B14 Boston, MA 02215

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

PERMISSION TO SHARE INFORMATION

A. Patient's Name (*please print*):	Date of Birth: _____ / _____ / _____ month day year	Medical Record Number (*if known*):
Address:	Telephone Number:	Social Security Number (*last 4 digits*):

B. Permission to Share: I give my permission to share my individually identifiable health information, which may include protected or privileged information in written and/or verbal form. Please check applicable: ☐ Written ☐ Verbal

From:	**To:**
Name: _____	Name: _____
Address: _____	Address: _____
_____	_____
FAX Number: _____	FAX Number: _____
Telephone Number: _____	Telephone Number: _____

C. Reason for Release of Records: _____ A copying service fee may be charged; including for records that are sent directly to a patient. (Please see Instructions on reverse side)

D. Information to be released for treatment dates: From _____ /_____ /_____ through _____ /_____ /_____

E. Documents to be released: **Please check YES or NO for <u>each</u> of the following options**

YES	NO		YES	NO	
☐	☐	**Medical Records Abstract** (i.e., History & Physical, Operative / Procedure Reports, Clinical / Office Notes, Discharge Summary, All Diagnostic Test results)	☐	☐	Radiology Reports
☐	☐	Progress Notes	☐	☐	Laboratory Reports
☐	☐	Discharge Summary	☐	☐	Pathology Reports
☐	☐	Photographs / Videos	☐	☐	Operative Notes
☐	☐	X-Rays / X-Ray Reports (please specify): _____	☐	☐	Entire Medical Record
					Other (please specify): _____

F. Privileged or Specifically Protected Information: **Please check YES or NO for <u>each</u> of the following questions**

YES	NO		YES	NO	
☐	☐	Alcohol or Drug Abuse Treatment	☐	☐	HIV / AIDS diagnosis and/or treatment: I specifically give permission to share information in my record about my HIV / AIDS diagnosis and/or treatment information. Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70F.
☐	☐	Sexually Transmitted Diseases			
☐	☐	Domestic Violence Victim's Counseling			
☐	☐	Sexual Assault Victim's Counseling			
☐	☐	Communication between patient and Social Worker			
☐	☐	Psychiatric Health – mental health information including communication between a patient and a Psychiatrist, licensed Psychologist, and Psychiatric Clinical Nurse Specialist	☐	☐	Genetics Testing: I specifically give permission to share Information in my record about my genetics testing (excludes therapeutic genetic tests). Initial here to specifically authorize its release _____ as required by M.G.L. c.111, § 70G.

G. I understand and agree that:

- The information which I authorize for release may be re-sent and no longer protected by federal privacy regulations
- I will be charged a fee for information that is sent directly to me
- I decline the opportunity to inspect or copy the information released
- I have received a copy of this authorization
- I may take back this authorization at any time by notifying the physician / hospital / clinic / organization from whom I am requesting this information, provided that the information has not already been released
- This authorization is voluntary
- My treatment will not be conditioned on the completion of this authorization.
- My questions about this authorization form have been answered

H. This authorization expires 12 months from the date it was signed OR as specified: _____ /_____ /_____
If not specified, this authorization will expire 12 months from the date it was received.

I. X_____ _____ **OR**
Patient's Signature Print Name

X_____ _____ **and** _____
Signature of Person authorized to sign for patient Print Name Relationship to patient

Date: ____/____/____ **Time:** ___ ___ : ___ ___ ◯ a.m. ◯ p.m.

Distribution: **White = Medical Record** • **Canary = Patient** **[Directions: Please See the Reverse Side]**

Complete if record is released to patient or authorized representative of the patient

For BIDMC Use Only

Date: _____ /_____ /_____

Information Released By: _____ Contact Number: _____

Clinic / Office: _____ Number of Pages: _____

Patient / Authorized Representative Identification Verified:

☐ License ☐ State ID ☐ Passport ☐ Other Photo ID: _____

Guardian, Executor of the Estate, Healthcare Proxy or Power of Attorney for the patient:

☐ N/A ☐ Copy of legal document (authority to act on behalf of the patient) received

Instructions to Complete the Authorization to Release Protected Health Information

Please follow these instructions carefully when completing the authorization form. The form must be entirely completed. Failure to do so may result in a delay in processing this request to release your medical record information. Please follow these steps and leave no box blank:

A. **Patient Name, Address, Date of Birth, Medical Record Number, Telephone Number and Social Security Number:** Print the name, address, date of birth, medical record number (if known), telephone number and the *last 4 digits* of the Social Security Number of the patient to whose protected health information ("medical record") is being released.

B. **Permission to Share:** Note: Faxing service is available for urgent medical care only.
From - Print the name, address, fax number and telephone number of the organization or individual from whom the medical record is requested.

To - Print the name, address, fax number and telephone number of the organization or individual who will receive the medical record.

C. **Copying Service Fee for Records:** If you wish to have records sent to you directly; you will be charged a fee and will be billed by invoice. If you have questions about the copying service fee for records sent directly to you, please contact the BIDMC Correspondence Manager at 781-234-0851, Monday – Friday 8:30 AM – 5:00 PM.

D. **Treatment Dates**: Insert the treatment date or date range of the medical record you are requesting to be released.

E. **Documents to be Released**: Check each box YES or NO to identify the type of document you are requesting to be released. Please fill-in all boxes.

F. **Privileged or Specifically Protected Information**: Check each box YES or NO to indicate each type of information you are authorizing for release. Please fill-in all boxes. If you had testing, diagnosis or treatment for any condition(s) as described under the "specifically protected" section, it is required that you place your initials in front of the section(s) that describes the type of information to be released.

G. **Understanding/Agreement**: Please read the important information in this section.

H. **Expiration Date**: Insert the expiration date. If not specified; then this authorization will be valid for 12 months.

I. **Patient or Authorized Representative Signature:** The patient whose medical record is being released must sign and date the authorization OR the Authorized Representative of the patient to whom the medical record pertains must sign and date the authorization.

Please note: If the individual signing the authorization form is a Guardian, Executor of the Estate, Healthcare Proxy or Power of Attorney for the patient, that person must submit a copy of the appropriate legal document, which proves authority to act on behalf of the patient. This must accompany the authorization form.